VISIT TO AIDS PROJECTS.

TRIP REPORT
INDIA

22.10.93 - 21.11.93.

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Abbreviations

AIDS	Acquired Immuno Deficiency Syndrom
BEGECA	Beschaffungsgesellschaft mit begrenzter Haftung für kirchliche, caritative und soziale Einrichtungen
CHAI	Catholic Hospital Association of India
CMAI	Christian Medical Association of India
CMC	Christian Medical College
CSI	Church of South India
CSSS	Catholic Social Service Society
CSW	Commercial Sex Worker
EC	European Community
ECHO	ECHO International Health Services Limited
ELISA	Enzyme Linked Immuno Assay
FP	Family Planning
HC	Health Centre
HIV	Human Immuno Deficiency Virus
HQ	Headquarters
IEC	Information, Education, Communication
IGSSS	Indo German Social Service Society
IHO	Indian Health Organisation
MCCSS	Madras Christian Council of Social Services
NACO	National AIDS Control Organisation
NGO	Non - Governmental Organisation
OPD	Out - Patient Department
PHC	Primary Health Care
SIAAP	South India AIDS Action Programme
STD	Sexually Transmitted Disease
TB	Tuberculosis
TBA	Traditional Birth Attendent
THQ	Technical Headquarters
TOT	Teaching of Trainers
PAM	Physicians Responsible for AIDS Management
PHIV	People Living with HIV
PWA	People Living with AIDS
UPMB	Ugandan Protestantic Medical Bureau
UNICEF	United Nations Children Fund
VHAI	Voluntary Health Association of India
WB	Western Blot
WHO	World Health Organisation
ZACH	Zimbabwe Association of Church - Related Hospitals

Executive Summary

The trip to India was planned in co-operation with Misereor and many local partners in India. It was co-ordinated with various other European NGOs. From 22.10.93-21.11.93 I visited various Christian and non - Christian NGOs in South India and Delhi and contacted governmental organisations as well.

The main objective of the trip was to assess the present situation of HIV/AIDS in India and of the response of the Indian society to the pandemic. At the same time I offered to share information about the situation in other countries. The trip also gave the opportunity to discuss specific AIDS project proposals sent either to Misereor, EZE or CAFOD for funding.

It was encouraging to see that within a rather short time India went the long way from a rather complete denial - that AIDS may affect India as well - to an acknowledgement of the danger by most people nowadays. There was an overall acceptance now that HIV/AIDS may become or is already a serious problem for India. A high degree of awareness about the challenge of HIV/AIDS was found in the National Programme, the visited State AIDS Cells and NGOs, and individuals I met in the street. Awareness is the first step to a successful AIDS programme.

As in other countries in the beginning of the pandemic irrational fears have led to a high degree of discrimination of people infected or affected by HIV/AIDS. Practices like imprisonment, isolation in rehabilitation homes etc. are no longer supported officially, however their occurrence at least not long ago was reported. Loss of work, rejection from hospitals and schools and isolation from the family do still occur not unfrequently. Some of my contacts said that it will be very difficult to overcome discrimination in India, because discrimination is high even for diseases like tuberculosis (TB), leprosy or other sexually transmitted diseases (STDs).

Basic facts about AIDS are known now by most people, though there are still a lot of misconceptions and/or lack of detailed information. Everywhere, people seem to be interested to learn more about the pandemic, to get information on HIV/AIDS. Many programmes aim to increase such information and to give education about HIV/AIDS. Own IEC material is often developed. I saw wonderful hand-drawn posters and flip-charts. These hand-drawn material are adapted to the local culture and use the local language. They seem to be much more appropriate than printed material from elsewhere. The production of such local material should be further encouraged and financially supported if necessary. In most places I was asked to share information with key personal. I was assured that any support in information given by our Department would be appreciated also in the foreseeable future.

Everywhere in India there is a lack of trained counsellors. At the moment neither pre- and posttestcounselling nor counselling of people at risk (e.g. people suffering from other STDs) is done in most places. With the increasing number of people who will be detected HIV- positive in the near future, the need for counsellors will increase quickly. Some NGOs have plans to set up a counselling training programme. Such training of counselling should be supported urgently.

Sexually transmitted diseases are frequent. A baseline survey revealed a STD in > 9,7 % of women attending an antenatal clinic in Kerala. However many patients, esp. women do not seem to get adequate treatment. Due to feelings of shame or fear of being blamed many women do not contact medical professionals at all. Others seem to get inadequate treatment through private

practitioners, quaks or pharmacists. In most hospitals I heard that STDs are not treated (frequently). The few STD- patients coming to hospitals are usually referred to specialised STD - clinics.
STD - treatment is an important measure for AIDS - prevention. STD-treatment is possible without sophisticated laboratory support. It can be given at all levels of health care. Training of staff in clinical management of STDs and supply of efficient drugs to health facilities seem to be major keys for AIDS prevention in India in future. Strengthening and support of such programmes seems to be of major importance.

The National AIDS Control Organisation (NACO) became functional in 1992. Main activities so far were: making general recommendations for the State's HIV/AIDS policy, promotion of State AIDS Cells in all States, promotion of zonal blood testing centres, strengthening of STD - clinics, development of curricula and training manuals for the training of multiplicators, co-ordination of HIV/AIDS programmes with WHO and funding agencies etc. Concerning ethical questions the NACO generally follows the recommendations of WHO: e.g. testing for diagnosis is recommended only if ther is informed consent of the client and if facilities for counselling and support are available.

Implementation of the HIV/AIDS policy is the responsibility of the different State AIDS Cells, that work under the State's Minister of Health and Welfare. Until now in many States the implementation of the programme still does not seem to be very effective. Different reasons for this were given: the short duration of the programme, lack of interest in HIV/AIDS in some States, lack of structures enabling communication and delivery of funds from the National to State level etc. According to the NACO, funding for NGOs is intended via recognised bigger NGOs. Implementation of this NGO funding will start soon in Maharashtra and Karnataka, while, at least in some other States the implementation might need more time.

In Christian hospitals the staff generally seem to be very concerned about AIDS though most staff members until now never recognised a person with HIV/AIDS. With the high rate of undetected infections however it is very likely that everybody already treated a person with HIV-infection either in the OPD or in the wards without knowing it.

Irrational fears of casual transmission are one reason for the high demand for HIV-tests and/or isolation wards in many hospitals. In many projects I had intensive discussions about ethical questions concerning these topics. In order to continue the information exchange I was asked to send additional information material from our resource centre.

It is known now that the success of any prevention programme depends on the level of discrimination against affected people in the respective society. Acceptance and integration of AIDS care in hospitals can help to overcome discrimination. Christians in many countries have shown that they can set an example by accepting those affected by HIV/AIDS without discrimination. In hospitals this means to treat all PHIV and PWA in general wards, OPDs and/or at home. The manner how the first AIDS cases will be treated in Christian hospitals in India in the near future might determine the reaction of other Indian hospitals. This finally may determine success or failure of prevention programmes in India. In line with the policy of the governmental national programme as given by the National AIDS Control Organisation (NACO) and WHO I therefore not recommend to establish or support special AIDS wards in Christian hospitals.

It was interesting to see that a lot of NGO activities around AIDS already exist. AIDS NGOs target mainly groups that are working with commercial sex workers (CSW) or truck drivers e.g. groups with known high risk behaviour. Many non-AIDS-NGOs are ready to integrate AIDS activities into their programme. Further training and support of these NGOs are needed. They offer a chance to start AIDS activities in an integrated approach right from the beginning.

Though infection rates are increasing quickly in India at the moment, there seems to be hope that the spread can be stopped earlier than in other countries. India has the advantage that much more is known about the pandemic nowadays than ten years ago when HIV was spreading in Africa. Successful interventions are known. The close co-operation of NACO with WHO does give the chance to learn from previous experience. The policy of the NACO is encouraging. Training at the moment aims at high level multiplicators. AIDS awareness has risen considerably in the general population during the last two years. NGOs are willing to integrate AIDS into their programmes. All these aspects are facilitating prevention.

Counter-productive at the moment however is the strong tendency for discrimination. The future development of the pandemic will depend much on how discrimination can be overcome. Amongst others training of counsellors, integrated care in hospitals, and treatment of STDs without blame at PHC-level might facilitate this process. Successful interventions based on a non-discriminatory acceptance of PWA will give India the chance to escape the dramatic impact of the pandemic seen now in countries of high prevalence.

Introduction

In the early eighties the AIDS-epidemic started spreading in certain population groups of industrialised countries and among African population groups almost at the same time. Primarily AIDS was considered to be a problem restricted to Africa and to some marginalised groups in industrialised countries. However in the meantime it became obvious that the HIV/AIDS pandemic has reached every country in the world. Recently dramatic infection rates were reported from Asia. Local responses to the pandemic are being developed. Donor organisations as well as the Department of AIDS and International Health at the Medical Mission Institute are subsequently receiving an increasing amount of applications for support of anti-AIDS-activities in Asia.

HIV (Human Immuno Deficiency Virus) causes the same immuno deficiency all over the world. However not only opportunistic infections vary according to regions, but social reactions to this disease differ widely and are dependant on the cultural setting. In order to give appropriate assistance to NGOs working in AIDS prevention or care it seemed necessary to learn more about the specific situation in Asia and especially in India. The trip may be seen as a follow-up to a trip by a former team member (Dr. Barbara Krumme) to India in 1991.

The trip was planned in co-operation with German funding agencies, esp. Misereor, the funding agency of the German Catholic Episcopal Conference. As our Department is working in close co-operation with Caritas and Protestant donor agencies like EZE, Bread for the World and DIFÄM, it was agreed that project partners of those organisations should be visited as well. The programme of the visit was co-ordinated with CAFOD and Caritas Internationalis.

Objectives of the Trip

The main objectives of the trip were:

- - to assess the present situation concerning HIV/AIDS and to learn about responses of the Indian society to the pandemic. Of course it was neither intended nor possible to get a comprehensive overview for the whole of India. Considering the big cultural diversity of Indian States and the long distances, this assessment could be done only in a few places visited. Furthermore a first visit to this subcontinent could just allow a preliminary insight into problems related to HIV infection;
- - to get into personal contact with church-related groups who are already working or want to include AIDS control measures in their programmes;
- - to share the information gained by our Department through contacts to various regions in Latin America, Africa and industrialised countries as well through scientific literature and visits of congresses;
- - to discuss with project holders in India their recent AIDS project proposals sent to Misereor, EZE, DIFÄM or CAFOD.

Schedule of the Trip

The majority of visited persons / institutions had been in contact previously with our Institute and / or the above mentioned donor agencies. Many had invited us to their places. Due to the time limit the travel route had to be restricted. I chose to visit places in South India and Delhi because many NGOs working in AIDS programmes in India, known to our group already, are active in

this regions. For the travel route see the map in Annex 1. The following institutions were visited (for a complete list of institutions and persons contacted see Annex 2 and Annex 3).

National and State AIDS Programmes	NACO (Delhi), AIDS Cell (Bombay)
Church related (co-ordinating) organisations	CSI (Madras), CRI (Bangalore), CHAI (Hyderabad), VHAI, CMAI , Caritas India (Delhi)
Hospitals	CMC (Vellore), St Thomas Hospital (Chettupattu), Holy Spirit Hospital (Bombay), Holy Family Hospital (Delhi), different CSI Hospitals in Tamil Nadu, Catherine Booth Hospital (Nagercoil), Governmental Hospitals in Delhi
AIDS - NGOs	SIAAP (Madras), IHO (Bombay)
Integrated rural/urban development organisations	MCCSS, Prepare (Madras), Bharati Women Development Center (Kanacham)
Anti - drug abuse NGOs	Trada (Kottayam, Trivandrum), ATMATA Kendram (Changanacherry)
Women groups, individuals, lay persons	in private practices, slums, trains, rikschas etc.

Health Indicators and Health Services

Private medicine plays an important role in India. Access to the private sector however is limited. Difficulties to get adequate private treatment exist especially in rural areas and in the explosively growing slum areas of the cities. Dhalits (scheduled classes) are mostly affected. Annex 4 shows the present basic health indicators of India.

Christian Hospitals in India presently face a difficult situation Competition with mushrooming private clinics is leading to under-utilisation in many places, especially by the richer population groups. The system of subsidising prices for the poor by the rich gets under pressure or is already collapsing. The costs for sophisticated technology needed to satisfy the rich patients finally add to admission costs for the poorer section of the population as well. Rikscha - drivers told me that it is unaffordable for them to seak treatment in a Christian Hospital like the Holy Family Hospital in Delhi. Many mission hospitals had to be closed due to financial problems during the recent years.

HIV/AIDS Prevalence in India

Until September 1993 **459 AIDS cases** were reported in India (fig. 1 and Annex 10). However, this low number should not mislead. Like in any country in the beginning of an epidemic there is a lot of under-diagnosing and under-reporting. The National AIDS Control Organisation (NACO) **estimates** that already **10,000 to 20,000** people in India **have developed AIDS** (fig. 2).

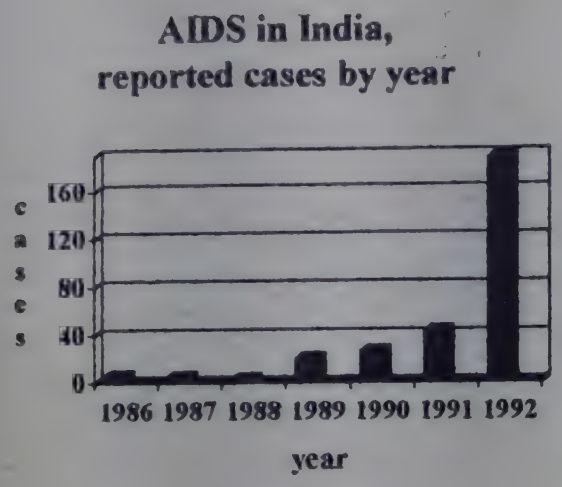

fig. 1

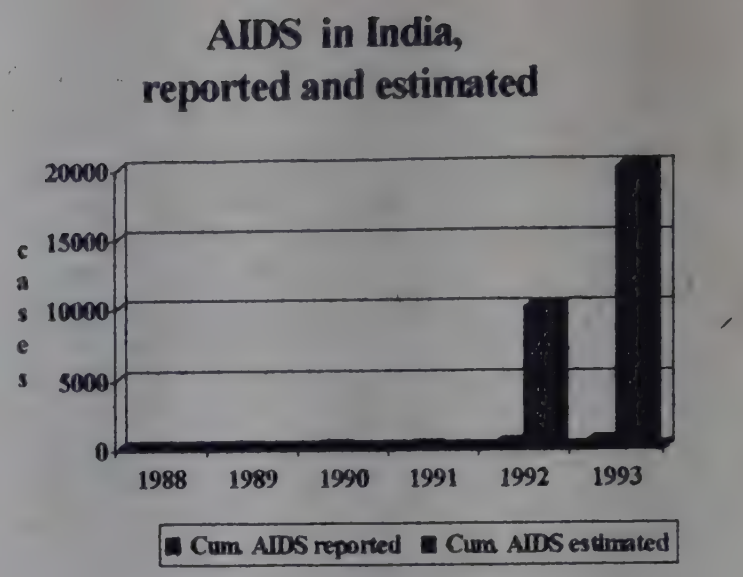

fig. 2

Source: National AIDS Control Programme India, Country Scenario - An Update, April 1993, Min. of Health and Welfare Government of India

Due to the extremely long incubation period of 8-10 years from HIV infection to AIDS, most people who have already acquired the HIV infection are still without any symptoms, and most of them are not aware of their infection. Surveillance data indicate that the **present rate of HIV infections** amounts to **1.6 million** showing a strong increase during the recent few years. It can be expected that most of the infected will develop AIDS during the next decade. It is expected that **1,000,000 AIDS cases** will have occurred until **the year 2000**.

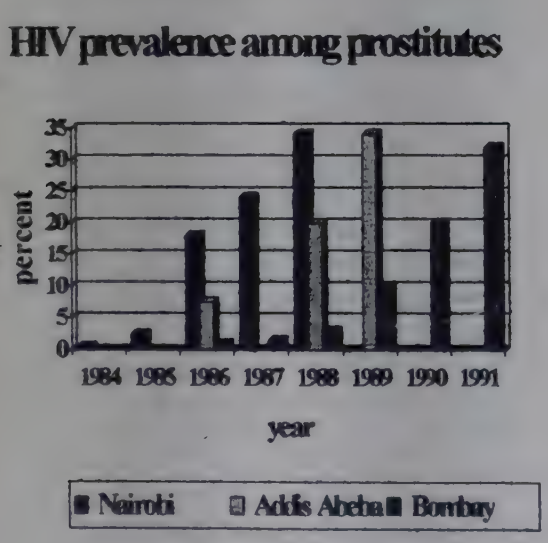

fig. 3

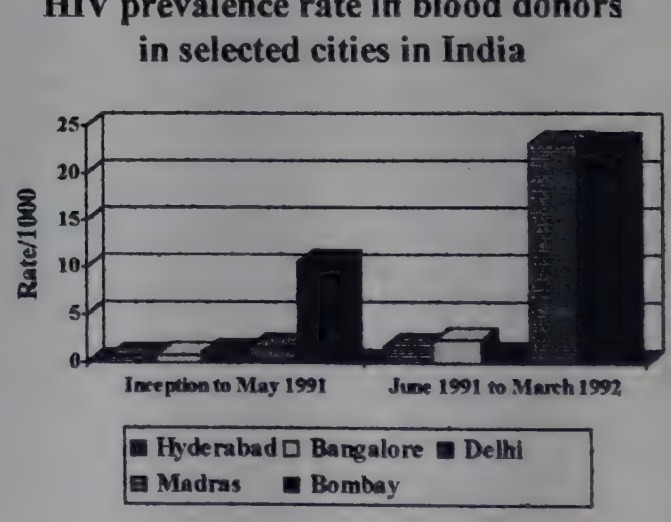

fig. 4

Source: National AIDS Control Programme India, Country Scenario - An Update, April 1993, Min. of Health and Welfare Government of India

According to an WHO-estimate the number of **infected people** will exceed **10,000,000 by the year 2000,** if no effective preventive measures are taken. Quickly rising infection rates, not only in persons with known or perceived risk behaviour (e.g. prostitutes) but also in blood donors, give reason for concern (fig 3 and 4). As shown in fig. 3 the prevalence increase in Bombay in the early 90ties seems to be comparable to the increase in Nairobi and Addis Abeba 3, resp. 6 years ago.

Maharashtra State and Tamil Nadu with their capitals Bombay and Madras are presently leading regarding the number of reported cases. They are followed by Punjab, Chatinga, Delhi and Kerala. As in other countries, HIV infection is spreading primarily in big cities. As a result of the presently strong migration in India however, the pandemic has already moved to rural areas.

Transmission

Main route of transmission

In India as elsewhere most cases are transmitted sexually. According to the NACO 75.3% of all HIV infections in India are acquired through sexual contact, followed by blood transfusions (12%) and injecting drug users (6.5%). Intravenous drug use is a serious problem in North East India especially in Manipur. In the places visited in South India the latter seems a rare cause of transmission, so far.

Co-factor of Transmission: STDs

According to a baseline survey of NACO, 9.7% of women attending an antenatal clinic in Kerala were infected with a STD (tab. 1). Inspite of this, in the places visited almost no STD treatment is given. The few known patients are referred to STD clinics. However, there is some evidence that many patients do not seek treatment at all, and that others just consult quaks or search self treatment in pharmacies. People may be ashamed to suffer from a STD and do not want to admit it; others fear to be blamed by medical staff. Lack of geographical or financial access are other reasons not to seek qualified treatment.

On hospital level not much seems to be known about STD-infection rates in India. STDs are sometimes perceived as rare diseases by staff members because people are not seen with such symptoms. There is an urgent need to strengthen STD care on all levels of the health system. Clinical management of STDs is possible. Sophisticated laboratory examinations are needed only in non - responders to primary treatment. STD treatment offers the chance for individual counselling of people at risk of HIV infection. Effective STD treatment in combination with counselling therefore offers a double opportunity for prevention.

Group	STD Prevalence	Syphilis Prevalence
Remand Prisoners males (N=200) females (N=50)	 9.5 % 36 %	 6.0 % 10 %
Industrial workers	1.2 %	0.8 %
Transport workers	5.2 %	4.4 %
ANC attendants	9.7 %	1.7 %
Rural males	5.6 %	3.6 %
Rural females	4.0 %	3.3 %

Source: National AIDS Control Programme India, Country Scenario - An Update, April 1993, Min. of Health and Welfare Government of India

Tab. 1

AIDS Awareness

Basic knowledge about AIDS seems to be widespread. All contacted persons and institutions had this information. Informal talks in the street and with women groups showed that even most people at grass-roots had heard about AIDS and knew the main routes of transmission.

At the same time this knowledge seems to be rather incomplete in many cases. Incomplete or wrong information is frequently causing misconceptions and myths. Such misconceptions are one of the main reason for irrational fears encountered everywhere. Though it is "known" that HIV is not transmitted casually or by mosquito bites, it is not really believed. For proper understanding as a precondition for believing it, more information on the pathology of transmission is needed. Background information is missing regarding the virus, the efficiency of transmission and the epidemiological evidence that casual transmission is impossible.

There is a strong demand for further information and education at all levels. Wherever I was, I was asked to share information with senior staff. All contacted persons / institutions were interested to get more information, originating either from results of scientific research or from field experience in other countries.

Irrational fears are most often the reason for isolation of and discrimination against people affected by HIV/AIDS. In many places I heard about HIV- positive people who were refused treatment in hospitals, about children of PWA, who were not admitted to schools or about family members of PHIV who lost their work place. At least in former times there was isolation and/or imprisonment in camps as well. In the past names of PHIV were published sometimes in newspapers. Subsequently those named weren often rejected by their own families, lost their work place and/or were discriminated in other ways by their communities.

I heard contradictory views about the likelihood of future acceptance of HIV- infected persons in the Indian society: While some people feel that the strong cultural bonds among family members will overcome discrimination rather quickly, others are afraid that this might not be easy. Even at present stigmatisation is said to be rather high for common diseases like tuberculosis (TB), leprosy and other STDs. Some medical practitioners even feel that they should not break the news of a TB infection to a family because of likely bad consequences for the affected individual. According to these reports at least some doctors treat certain diagnostic results with confidentiality. This opinion is in contrast to the repeatedly mentioned view that HIV-test results should not be treated confidentially, because the concept of confidentiality is allegedly not known in Indian families.

Not only in hospitals but also in the general population many people demand mandatory testing of certain groups perceived to be at risk of HIV infection. Many persons still seem to believe that a mandatory testing programme for prostitutes will stop the spread of HIV/AIDS. In the past, prostitutes were repeatedly tested by force and sometimes imprisoned if found to be HIV-positive. Though this is no longer recommended officially, there are still reports of police raids in red light districts with the aim to collect prostitutes for HIV-testing. In Bombay the State's AIDS Cell has a training programme now targeting policemen in order to stop such practice. The Head of this State's AIDS Cell acknowledges what has been learned in many places: mandatory testing is driving prostitutes (as well as other groups at risk) underground, where they can no longer be reached for AIDS prevention programmes including treatment of other STDs. Mandatory testing thus may increase the spread of HIV and not decrease it.

IEC-Material

IEC material is produced in most projects. Many organisations are drawing own posters by hand or are developing their own flip charts. Such material is usually adapted to the local situation and of course uses the local language. Printed material is scarce in many places, however probably not so much needed, because everybody seems to be able to produce own posters etc. Annex 6 contains a list of material produced in some of the visited institutions.

Responses of the National AIDS Control Organisation (NACO)

The National AIDS Control Organisation (NACO) was established in the beginning of the Nineties. It is supported by the World Bank and WHO. The NACO is working under the Ministry of Health and Welfare and started the implementation of the first 5-years programme only in 1992. The 5-years plan covers the period from 1992 to 1997. The budget amounts to $US 207 million of which about $US 100 million are approved at the moment. The Indian government contributes $US 13 million. International donors are: the World Bank - $US 85 million, USAID - $US 10 million, SIDA - $US 18 million, WHO - $US 1.5 million , NORAD, FORD etc..

The AIDS-programme of the NACO has the following components:

- Programme management: One of the main objectives is the establishment and support of State AIDS Cells in all States of India.
- Blood safety: According to the "Drugs and Consumers Act" HIV testing of blood transfusions became mandatory, meanwhile. 180 Zonal Blood Centres have been established (see Annex 7). Service in the Zonal Blood Centres is free. However the coverage by zonal centres is not yet sufficient, and in several places I learnt that blood is still given untested.
- Treatment and management of AIDS, reduction of the impact: NACO recommends an integrated approach for the treatment and management within the general health services. Universal precautions should be adapted for all patients - and not only for people with suspected of proven HIV- infection or AIDS.
- IEC: On national level seminars for doctors and college teachers are held. A curriculum for college students was developed and is pilot tested at the moment. Other training materials, e.g. for nurses and other staff, will be finalised in the near future.
- STD control: A baseline survey found high STD-infection rates even among the rural population. Treatment in many places was found insufficient. The NACO recommends to treat STD-patients on primary health care level. Clinical management is recommended. Through training, the staff at all levels shall be enabled to give this treatment. An upgrading of STD- clinics is recommended. They should serve as places for referral of non-responders or relapse cases.
- Condom programme: Condoms are imported and several brands are produced in India. They are distributed free of charge in health care facilities and through specific programmes. At the same time they are marketed at a subsidised prize. The cheapest condoms (*Nirodh*, 3 pieces for Rs 2) have found to be of insufficient quality. It was announced that this brand will be withdrawn from the market in the near future. Other condoms are available at Rs 3 - 7 per 3 pieces.

- Surveillance: 62 centres for anonymous testing have been established to enable better epidemiological predictions for the future.
- Operational research: Amongst others, it is planned to examine, if interventions that have proven to be successful in other regions, are of value in the Indian society as well.

Except for some nation-wide activities, The NACO functions mainly as an advisory and support body for the State AIDS Cells, because the responsibility for health and welfare in India lies with the State Governments.

Responses of State AIDS Cells

General aspects

Though State AIDS Cells exist in all States now, I was told that not all are very active. Lack of interest in the topic by some of the personnel in these AIDS cells and / or corruption were reasons mentioned. Existing structures sometimes seem to be inadequate for a fruitful co-operation between AIDS Cells, NACO and NGOs. Insufficient structures may hinder the implementation of a planned AIDS - programme - even if there is dedicated personnel.

NGO-Funding

Difficulties in transferring money from the NACO to State's AIDS Cells and further on to NGOs were attributed to such missing structures. Regulations and legal procedures have to be clarified e.g. who will be accountable, who might sign, to whom to pass on the money etc.
I was told that in **Maharashtra State** the preconditions for the transfer of money to NGOs do exist now. NGOs should make applications to the government. The government has set certain criteria for such funding. One of those criteria is that the NGO is already active and has a good reputation amongst other NGOs.
In **Tamil Nadu** AIDSCAP will start a programme in 1994 with one component being funding assistance to NGOs. Though in the NACO I was told that this money is not restricted to programmes with condom distribution, later I heard the opposite from a NGO.
In **other states** people complained that a governmental programme is rather non existent due to lack of good will and/or corruption and that NGOs do not receive any funding from the Government.

Experiences in Bombay

In states with active AIDS Cells the first interventions are becoming visible now even at grass-roots. While in Madras and other places local NGOs said that they do not see any impact of the governmental programme, this is different in **Bombay, Maharashtra State**. Here I heard many positive comments, e.g. about IEC-campaigns, about the functioning of zonal blood centres and about programmes targeted at sex workers.

IEC in Bombay is done rather aggressively. In busses and local trains the following inscription is printed:

> Every half hour
> one person
> is infected with the AIDS
> virus in Bombay.

I joined a street drama targeting men in the surroundings of red light areas. The reactions of men to the drama were interesting: Many men seemed to be shocked by the play and concerned about their health after the performance. Most wanted to get the address of a STD-clinic after the end of the play.

Responses of Christian Hospitals

Knowledge, Awareness and Attitude

The staff in hospitals seems to be very concerned about the spread of the virus. AIDS education was given already several times for the higher level staff in most hospitals visited. However, there is still a strong demand for further education. Insecurity about the risk of hospital infection is high. People are highly interested to learn more about the pandemic. In some nursing schools, AIDS is introduced to the curriculum already. In Madras, I was shown a wonderful poster exhibition on AIDS prepared by nursing students of a CSI Hospital.

Even at hospital level few people ever saw consciously a person with HIV or AIDS. Regarding the low number of reported AIDS cases in India, this is not surprising. However, the chance that everybody working in the medical sector has already cared for one or more HIV-positive persons without knowing it, is high in a country with 1.6 million HIV- infected persons.

A person diagnosed to be HIV-positive or suffering from AIDS is rejected by most hospitals at the moment and sent to a medical college. Uneasiness about the treatment of AIDS, fear of losing other patients and fear of hospital infections are reasons. Fear of casual or accidental transmission in the All India Medical Institute led to the situation, that no staff could be found for the newly established AIDS-ward.

HIV Testing

In almost all countries of the world, the call for testing is / was one of the first reactions at the onset of the HIV/AIDS epidemic. It occurs at a moment when the risk for the country is acknowledged, but when, at the same time, a lot of prejudices and irrational fears still exist. The technical solution "testing" is perceived as a way to reduce transmissions. This however has never been proven. Despite a lot of research on possible preventive aspects of testing, there is no evidence for this assumption.
Many doctors promote HIV- testing before surgery, in antenatal care clinics, for groups suspected of risky behaviour and/or for all patients. Where a sufficient number of tests are available, testing is done - often without adequate facilities and expertise for counselling. This procedure is not in line with the recommendation of NACO (and the view of WHO). According to their recommendation testing should be restricted to anonymous testing for surveillance and blood safety. Testing for clinical diagnosis is promoted only if there has been the informed consent of the patient after pretestcounselling and if posttestcounselling and support is available for PHIV/PWA.

As mentioned before: there is almost no counselling in the country. Testing is performed without pretestcounselling and often without informed consent. This is done despite the fact, that, according to an Indian psychiatrist, almost 18% of all HIV- positive people consider or commit suicide after being confronted with the diagnosis. Pre- and post-test counselling should be obligatory in all programmes with non-anonymous HIV-testing.

Private doctors and laboratories play a significant role in health care in India. If HIV-testing is introduced into private practice without counselling, the impact will be disastrous. One HIV test is available for Rs 60 to Rs 90 (for value of money see Annex 5). A private laboratory technician visited reported that he had received training in HIV-testing by a pharmaceutical company and that he regrets that until now he has not had the possibility to buy the tests.

Treatment of PHIV / PWA

As a result of the growing awareness about HIV / AIDS, in many hospitals presently discussions take place whether to treat AIDS- patients or not. If treatment is considered at all, often a special AIDS ward is planned. A number of arguments were mentioned in favour of such a special ward. According to my opinion however a special ward may create new problems without solving the old ones. In the following table (tab. 2) I want to summarise some of the arguments for and against such special wards.

According to the NACO, presently one to two HIV- positive persons are treated per week on average in an OPD of a 300 beds hospital. Against this background the above mentioned discussion, whether to treat HIV/AIDS or not, seems rather senseless. Already now, such persons are treated in the normal ward or in the normal OPD. It will never be possible to avoid it, because most infected people cannot be detected clinically during the first 10 years after infection and because it is unrealistic to test all patients.

In future the reaction of the public towards PHIV / PWA will be strongly influenced by what is done today on hospital level. Integration of AIDS affected in the normal ward will decrease discrimination and stigmatisation in the whole society.

During the last ten to twelve years, the pandemic has taught us that there is a strong interrelation between discrimination, care and prevention. Where AIDS care is integrated into society, and where PWAs receive proper care without being stigmatised, in these places prevention is most successful. In many places of the world the Christian faith has led to such an integrated care for patients, which in turn led to acceptance of preventive measures by the population. In the present situation in India, special AIDS wards would have the opposite effect and therefore are not recommended.

Response of Co-ordinating Christian Bodies / NGOs

Church of South India (CSI)

Under the Church of South India: Council for Healing Ministry more than 100 health facilities are working, among these more than 30 are able to give blood transfusions. Particularly the rural hospitals face serious difficulties in getting blood tested for transfusions as the number of existing zonal testing facilities is not yet sufficient. CSI wants to acqire HIV-tests for these hospitals and at the same time is planning IEC activities for hospital staff as well as for other multiplicators (teachers, priests, etc.). CSI has applied for funding of the project from EZE / DIFÄM.

Discussion about Special AIDS Wards in India at the present stage of the pandemic.

Arguments mentioned to support the establishment of special AIDS wards	**Arguments in favour of integrated care in a normal ward and/or OPD**
The risk of hospital infections for other patients and/or staff is perceived greater without an AIDS ward.	The rate of undetected, often symptomless HIV-infections will remain much higher than the number of identified PHIV/PWA even if all suspected cases are tested. Universal precautions in all wards are therefore essential. Through a feeling of false security these universal precautions may be neglected, if a special AIDS ward exists.
A special ward would allow a economic use of scarce resources for hospital safety	As said above universal precautions are obligatory even if there were a special ward. No resources would be saved
A better treatment could be given in a special ward.	AIDS is a syndrome of opportunistic infections, and in most cases patients do not get any specialised treatment except AZT - if available and affordable. This treatment can be given easily in the normal ward. Sophisticated other drug therapy which is available in the U.S. is at present not affordable for the majority of PWAs in India.
Young doctors could be better educated about AIDS-treatment.	In most cases patients do not get any specialised treatment except AZT - if the latter is available and affordable No specialisation of doctors is needed.
In the U.S.A at least some PWA prefer to be treated in special wards.	AIDS patients in America may prefer to be treated in special AIDS- wards. However the situation in the U S A is different from the one in India. In the U.S., mostly homosexuals and drug users are affected. They are marginalised groups in society and have therefore strong relations with each other and only few connections to their original families Inside their groups, discrimination of HIV/AIDS has been reduced. In India, mostly heterosexuals are affected. They are not marginalised and are living with their families. If they are treated in special AIDS wards, their diagnosis would be revealed to the public, esp their family. Isolation and discrimination in the hospital would lead to isolation and discrimination in the family. Special AIDS wards thus would lead to a further increase in discrimination and stigmatisation. It is right that HIV infected people can be supported very much by other PHIV / PWAs. However, this is true only if the "coming out" is voluntary in a place where confidentiality can be kept. An AIDS ward cannot replace a self-help group!
Treating HIV/AIDS in the normal ward might lead to a drop of occupancy rates in all wards. Esp. the richer population groups might be afraid of hospital infections. They would prefer treatment in other private facilities. This would create severe economical problems for mission hospitals.	The economical argument that esp. rich patients would no longer come to hospitals that admit AIDS-patients to normal wards may be right at the moment. With a growing awareness about the infection however people will certainly know soon that an AIDS ward will not prevent HIV- infected people to be admitted with other diseases to the normal ward. People will understand quickly that they cannot get infected if universal precautions in the hospital are kept. The drop in occupancy rates therefore will be only a rather short-lived phenomen.

tab. 2

Council of Religious of India, Section Bangalore (CRI)

The Bangalore Section of the Council of Religious of India invited me to take part in a seminar organised for about 160 congregations. 300 mostly female religious attended. The one-day seminar was organised by a White Father, Fr. Matthews Pathilchirayi. At the end of the seminar it was decided to set up an action group on AIDS which wants to organise further seminars for individual congregations.

Madras Christian Council of Social Service s (MCCSS)

MCCSS has started its AIDS programme in 1991 in five slum areas. A community-oriented AIDS awareness programme was initiated. Information campaigns are combined with rallies for human rights and legal assistance for people infected with HIV/AIDS. MCCSS wants to extend the programme to 100 slum areas and sent project proposals to EZE and to CAFOD.

Catholic Hospital Association of India (CHAI)

CHAI published some good articles on HIV/AIDS in their newsletter *AIDS Action* and recently in *The Catalyst*, a newsletter for the youth. A part- time AIDS co-ordinator was appointed half a year ago within the Community Health Department. It was intended to have a one day seminar on AIDS during the Golden Jubilee Celebration of CHAI. Unfortunately due to the recent earthquake in Latur the whole celebration - except a handmade poster exhibition on AIDS - was cancelled.
The AIDS-Co-ordinator of CHAI is preparing presently an action plan for future HIV/AIDS - activities of CHAI. Training of midlevel staff in counselling and care will probably become one of the main objectives of his plan. Another objective will be IEC to all 2560 CHAI members through the existing CHAI-channels (regular newsletters and other communication structures). Training in diagnosis and treatment of STDs at all levels of care was another possible objective discussed during my visit. CHAI might send a proposal for such an AIDS-project to MISEREOR in the near future.

Voluntary Health Association of India (VHAI).

Presently the main focus of VHAI's work in AIDS is the production of education material. Several locally adapted posters, leaflets and flyers were produced. All seem to be of high technical quality. A coloured comic booklet will be reprinted in a high number. VHAI received recently the approval for funding of this reprint by a donor organisation.

VHAI runs direct projects mainly in two states, in Manipur and in Tamil Nadu. The project in Manipur is concentrating on drug users: operational research in drug user is done and assistance to a prevention programme is given.
Recently VHAI got the approval for funds from the EC for AIDS-projects in several other States of North India.
The NACO mentioned VHAI as an organisation that could identify small NGOs for receiving governmental NGO-funding.

Christian Medical Association of India (CMAI)

In co-operation with NORAD and the NACO CMAI has started a nation-wide training programme for doctors. 1200 doctors from district hospitals and 300 doctors from mission hospitals are trained in five days workshops. Training is carried out decentrally, each group comprising about 30 doctors. 22 doctors, who were trained themselves by a 10 days seminar and

who were sent to Africa (Zimbabwe, Uganda) for an exposure programme, are the trainers. Despite an initial opposition against the exposure programme, the AIDS Co-ordinator of CMAI, feels that the exposure has been very useful, because the doctors came back emotionally deeply involved.

Indo-German Social Service Society (IGSSS)

The Indo-German Social Society did not get many requests for AIDS projects so far. However Mr. Joe d'Souza and Mr. Dominic d'Souza feel that AIDS-projects should get higher priority. IGSSS wants to increase awareness among NGOs with the aim to integrate AIDS - components into all programmes.

Caritas India and Catholic Bishops' Conference (CI and CIBCI)

Caritas India did also not yet receive many project proposals on AIDS. I was informed that CI wants to encourage NGOs to start AIDS projects.
During the past meeting with Sr. Maura O'Donohue it was proposed to include AIDS into the schedule of the Bishops' Conference (CIBCI) in February. Until now this does not seem to get realised. Caritas India is still trying to get AIDS on the agenda, however, the chance that this will be successful is small.

Responses of AIDS NGOs

South India AIDS Action Programme (SIAAP)

In the first phase SIAAP aimed at the training of NGOs in HIV / AIDS and promoted AIDS activities of these groups. SIAAP did not perceive this programme as too successful and stopped it. However, I heard in places so far as Tanjavur and Hyderabad that NGOs were stimulated by SIAAP's seminars to start their own activities.
From training of NGOs SIAAP later shifted to work directly with communities displaying risky behaviour (e.g. truck drivers and prostitutes). The CSW-programme in Madras claims to reach > 10.000 sex workers. The main activity is the distribution of condoms by street workers. In the street there is no possibility for individual counselling. It was therefore decided to set up a place where counselling can be given and where STDs are treated. In addition, a meeting of sex workers takes place once per week in the office (about seven to twelve persons attend at present per week). It is hoped that the group could be the starting point for a local self-help group.
In a third phase, SIAAP (with the assistance of HIVOS) intends to train local sex worker communities in AIDS prevention and care and to give seed funds and free condoms to those NGOs for a period of six months. The programme already started with staff from two NGOs being trained at the moment through SIAAP.

Indian Health Organisation, Bombay

IHO is working with CSW in Bombay since a long time. It is one of the first projects that used the co-operation of peer educators from the sex worker communities for IEC. Additionally medical care is provided for prostitutes by mobile care teams. In Bombay three big vans are available for this purpose. There seem to be conflicts between IHO and the AIDS section of Bombay Municipality as well as the State AIDS Cell of Maharashtra.

Outside Bombay IHO intends to set up a centre for prostitutes and their children especially those who are HIV-infected. IHO will apply for funds for this project to MISEREOR and the EC. Other governmental and non-governmental groups visited in India do not support this approach.

Responses of NGOs Working against Drug Abuse

Total Response Against Drug Abuse (TRADA)

TRADA is operating five anti-drug centres in South India. I was told that they include AIDS as a topic in the training of their staff. Drug abuse is seen as one condition leading to risky sexual behaviour. Therefore it is planned to include AIDS activities into all programmes. In Trivandrum a small AIDS - centre: "Heal India", was established. The staff of this centre lectures gives lectures, produces IEC material, and organises exhibitions. Training of trainers and the foundation of a self-help group is intended. A project proposal was sent to CAFOD.

ATMATA Kendram

ATMATA took over a drug abuse centre from the Catholic Social Service Society of Changanacherry. This centre has to be re-established. At that moment only two patients were admitted.

ATMATA wants to do AIDS awareness campaigns in the diocese. Target groups identified are students, teachers and parents. I was told that the Catholic Social Service Society in Changanacherry intends to set up an AIDS project as well. Co-ordination of these two activities seems to be necessary. ATMATA will review and actualise the project proposal sent to MISEREOR.

Responses of Integrated Rural / Urban Development Organisations

Prepare

Prepare a NGO founded 20 years ago, is working in rural integrated development projects. Main objective is the empowerment of the scheduled classes (dhalits).
AIDS programmes were initiated in three States. In Madras, main activities focus on IEC at small and bigger industries and in work with prisoners (in one prison, homosexuality is acknowledged as an important risk factor for the prisoners!). In Andhrapradesh the IEC programme focuses on transport corporations, on non-AIDS NGOs and on school youth. In Tamil Nadu (Trichy) IEC is given to students on college level and for animators of adult education. Round tables with community leaders and influential citizens were organised to gain access to the industries and unions.

Bharati Women Development Centre (BWDC)

The BWDC is a small rural NGO working near Tanjavur. In an integrated development approach the BWDC focuses on empowerment of the rural population, esp. women. The NGO is working at grass - roots with the participation of the community. A simple office situated in a rather remote village is part of their philosophy: to live and work with the village community.

Amongst others the BWDC is running two income generating projects for women. Now the BWDC wants to set up an AIDS programme. The programme shall have two main objectives: IEC for the rural population and AIDS prevention work with lodgers and sex workers in two nearby towns (one of them is Valeikanni, a big pilgrim centre, where prostitution seems to be growing). The BWDC sent a project proposal to MISEREOR for this AIDS project.

NGO Meeting in Hyderabad

Initiated by the AIDS Co-ordinator of CHAI, a meeting of NGOs which are interested in AIDS was called in Hyderabad at the occasion of my visit. The Deputy Director of the State AIDS Cell was invited as well. About 20 NGOs were attending. All seemed very interested in the topic of AIDS. Some had already integrated AIDS activities in their programme while others intended to do so in the near future. All were interested in experience from outside India. At the same time it seemed to be a welcome opportunity for them to meet the representative of the Government. It was agreed that a future meeting of this group should be planned in order to facilitate information exchange and networking between GO and NGOs.

Responses of the Private Sector

Everywhere in India there are private laboratory technicians and doctors. Private hospitals are growing like mushrooms. The middle and upper middle class seems to rely increasingly on this private sector. For the poor, access is limited. In the slum areas, insufficient treatment is often given by quacks.

Many of the private practitioners seem to be interested in financial success. However there are dedicated people as well, who try to assist the poor in their spare time. It was interesting to see the private practice of one gynaecologist, who had a full waiting area on a Sunday afternoon. Many women suffering from a sexually transmitted disease visit this doctor. Treatment was given after clinical diagnosis. Only in rather rare cases of relapses or non-respondence, a laboratory examination was done. The doctor stated that the laboratory diagnosis is not affordable for many of the patients. Patients would not come for treatment, if they would have to pay for laboratory examination as well.

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Gilada, Dr. I.S. (ed.), Tulasa and the Horrors of Child Prostitution, July 1993, Indian Health Organisation, Bombay.

MCCS Annual Report 1992-1993, Madras Christian Council of Social Service, Madras.

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National AIDS Control Programme India, Country Scenario - An Update, April 1993, Min. of Health and Welfare Government of India

National Workshop on Youth Action on AIDS, Workshop Report, Commonwealth Youth Programme, Asia Centre, Chandigarh 14-20 March 1993, The Department of Youth Affairs & Sports, Ministry of Human Resources Development, Government of India, New Delhi in collaboration with: National AIDS Control Organization WHO and UNICEF.

Rajan, Dr. B.P. (ed.), AIDS.1993, Tamil Nadu Dr. M.G.R. Medical University Madras.

Voluntary Health Association of India, HIV and AIDS - What Everybody Should Know, May 1993.

Annex 1

Map of India

Annex 2

Time Schedule of the Trip to India

22.10.93 - 21.11.93

Time	Institution	Main contact	Activities
22.10.93	Arrival		
23.10.93	Church of South India Council for Healing Ministry Madras	Dr. George Joseph Executive Director, Mr Bhasker	AIDS talk to about 30 CSI doctors, discussion about the AIDS project
	CSI Kalyani Hospital	Dr. Luke M. Muthu, Medical Superintendent	Visit to the hospital
24.10. 93	Missonary of Africa Council of Religious of India, Section Bangalore = CRI	Fr. Mathews Pathilchiray, Bangalore	Seminar with ~ 300 religious
		Dr. G D. Ravindran, Internal Medicine, St. Johns Medical College	Sharing of information on AIDS
		Dr. Prabha S. Chandra, Prof. of Psychiatry, Nat. Inst. of Mental Health & Neurosciences	Sharing of information on AIDS
	Holy Spirit Sisters, Bangalore	Sr. Amela, Sr. Joyce	Discussion about transmission and impact of AIDS and measures for prevention
25.10.93 - 26.10. 93	St. Thomas Hospital and Leprosy Centre Chettupattu	Dr. M. Aschhoff, Dr. Jop Histopath., research Dr. Rao, TB-clinic Dr. Haykumar - Leprosy Dep. Dr. Baskar - Laboratory	Demonstration of videos, AIDS discussion with core group of doctors
26.11.92	Christian Medical Center (CMC) Vellore	Dr Jacob John, Dr. Babu	Discussion about the Indian AIDS policy
27.10.93	South India AIDS Action Programme, Madras	Ms Shyamla Nataraj and her team	Discussion about the programme and sharing of information with field worker in training
28.10.93	Madras Christian Council of Social Services	Mr Benjamin Franklin, Mr. Susai Michael and field workers	Discussion about the AIDS programme and the new project, AIDS discussion with field workers in one slum
	Rainy Hospital, Madras	Dr. Rajkumari Sunder, Med. Superintendent, Convener: Madras Diocesan Board, senior staff	Discussion about AIDS with senior staff, visit to the blood bank and wards
	Kilpauk Parish Welfare Association, Madras	Rev. Fr. Thomas Simon, Parish Priest, Mr. James Ribeiro,President, Mr. S. Mendoza, General Secretary, Mr. E. Peirera, Treasurer, Dr. Olga Nazareth	Discussion about an intended MCH project of the Parish

29.10.93	Prepare, Madras	Mrs. Daisy Dharmaraj and her team	AIDS talk and discussion with the whole team of Prepare in HQ, discussion with AIDS team members in HQ and with field workers in Sriperambadur
	South India AIDS Action Programme, Madras	Ms Shyamla Nataraj and field work trainees	Discussion about the AIDS programme
30.10.93 - 31.1.93	Bharati Women Development Centre, Kanacham , Nagai Quaid-E-Millath Dt., Tamil Nadu	Mr M. Nagarajan, Secretary staff of BWDC, villagers	Discussion about AIDS in the context of rural development, discussion of the project proposal, talk to a village group
31.10.93	Private gynaecologiste in Thiruthuraipondi, Tamil Nadu	Dr. Indira	Discussion about STDs in women
	Private laboratory technician in Thiruthuraipondi, Tamil Nadu	Mr. Manimaran Venkateshwara STD patient	Observation of working conditions, discussion about STDs, unexpected meeting with an STD-patient
	Home of Elderly in Vailankanni, Tamil Nadu	Sister of Bonne Secours and two helpers	Discussion about the need for hospices for elderlies, ward round
1.11.93	CSI Mission Hospital, Madurai, Tamil Nadu	Dr. Rajev Chelladurai , Med. Superintendent (paediatrician and gynaecologist), CMAI representative of Madurai	Short discussion about AIDS in Madurai
1.11.-2.11.93	Catherine Booth Hospital, Salvation Army, Nagercoil, Tamil Nadu	Dr Mannam Ebemezer, Superintendent Major Cooper, administrator, Nursing principal, AIDS cell (heads of laboratory, nursing, administration, etc.)	Discussion about the AIDS programme and the project proposal, sharing of information with the AIDS team
3.11.93	Atmata Kendram, Changanacherry, Kerala	Fr. Thomas Kochelechemkalam and Bro. Bijo Pulukattu	Discussion about the AIDS project proposal, sharing of information with staff, visit to the ACCEPT Centre in Allepey
4.11.93	Trada, Aymanam, Kottayam, Kerala	Rev. Fr. George Kolath and Counsellors	Discussion about AIDS and anti-drug abuse activities. Visit to the planned training centre for counselling in Kottayam and to the drug centre in Aymanam
4.11.93 - 5.11.93	Healindia, Trivndrum, Kerala	Sr. Mercy, Dr. Johnson	Discussion about the AIDS programme and the projet proposal
6.11.93 -7.11.93	Christian Hospital Association, Hyderabad	Dr. Christopher Nathan, AIDS desk, Community Health Dep.(CHD), D. Sreenivas Rao, Training, CHD, Dr. Ravi, Head of the CHD, all other members of the CHD Fr. George Monjelil, President, CHAI-Kerala	Discussion about the AIDS programme, participation in the Golden Jubilee Celebration, participation in the CHAI evaluation session, interview for HAFA, discussion about future AIDS activities of CHAI
	Vijaye Marie Hospital, Hyderabad	Nursing staff	Visit to the hospital, sharing of information on AIDS with the staff

	St. Theresa Hospital, Hyderabad	Dr. Christopher Nathan, Nursing staff	Visit to the hospital
	State AIDS Cell and 20 NGOs from Hyderabad	Prof Dinesh Raj Mathur, Dy. Director of the AIDS Cell Members of NGOs	Sharing of information on AIDS with NGOs and Government
	CSSS Changanacherry	Fr. John Kochumalayil	Discussion about AIDS activities
	SPITNACS, Hyderabad	Mrs. Mary Gandikota	Discussion about her IEC - material
8.11.93	Flight to Bombay		
9.11.93	Indian Health Organisation, Bombay	Dr. I.S. Gilada Executive Director , IHO team, field workers Commercial sex workers Staff in the counselling center	Discussion about the AIDS programme and the new project proposal, visit to the Salvation Army Counselling centre, interview for IHO, visit to red light areas in Bombay (Kamathipura, Simplex Building in Pavwala Street, Falklands)
10.11.93	State AIDS Cell, Directorate of Health Services	Dr Subash Salunke, Director of the AIDS Cell Maharashtra Dr Jagtap, Ass Director	Discussion about the State's AIDS policy
	Health Office in Municipal Corporation	Dr. Thaneker, Dy Ex Health Officer AIDS STD Control and Prevention, Ms. Elke Gadjil, IEC	Discussion about the AIDS policy of Bombay, observation of a street play on AIDS
11.11.93	Holy Spirit Hospital, Andheri, Bombay	Sr Hermanelda Sr Bernadette (Administrator), Sr. Alfonsa (Deputy administrator)	Discussion about AIDS, sharing of information with nurses in charge (25 - 30 persons) especially on Christian responses in hospitals (isolation, ethical issues of testing, value of and responsibility for care)
12.11.93	Flight to Delhi		
13.11. - 14.11.93	Public Holiday		
15.11. - 20.11.93	Holy Family Hospital, New Delhi	Sr. Lucia Panikulam, Dr. Sridharan, Medical Superintendent Mr. Fanthome, Education Co-ordinator Ms Ann Thomas, nursing tutor Heads of Departments (~ 20) Heads of Nursing Care (~ 30) Senior doctors (~ 25)	Discussion about testing, session with Heads of Departments (~ 20), Heads of Nursing Care (~ 30) and senior doctors (~ 25) with intensive discussion about ethical issues of testing and care, round through the hospital, discussion about the project proposal
16.11.93	Caritas India, New Delhi	Mr. P.J. Lukose	Discussion about the AIDS ctivities of Caritas India
	Sree Narayana Kendra, New Delhi	Sree Narayana Kendra	Discussion about the project proposal
	UNICEF, New Delhi	Mr. L.N. Balaji, Health Section	Discussion about UNICEF's AIDS programme
17.10.93	Indian Social Institute, New Delhi AIDS Anti-Discrimination Movement	Sr. Shalini d'Souza, S.C.N., Director Women's Programme	Discussion about Sr. Shalinis work in AIDS

	Indo German Social Service Society, New Delhi	Mr Joe De Souza, Director M. Dominique De Souz	Discussion about the role of IGSS in AIDS control
	All India Institute of Medical Sciences, New Delhi		Short observational visit to the building
	Safdur Jang Gov. Hospital, New Delhi		Short observational visit to the building
	Health Centre in Janakpur, New Delhi		Short observational visit to the building
18.11.93	Christian Med. Association of India, CMAI, New Delhi	Dr. Daleep Mukarji, General Secretary, Dr. Bimal Charles, CHD Dr. Deepak Meshram - AIDS desk, Sen. Progr. Coordinaator	Discussion about the AIDS programme of CMAI
	Voluntary Health Association of India, VHAI, New Delhi	Dr. Sanjey Kapur, Senior Programme Officer, Mr. Raeh Sukumar, Communication Designer. Dr. Sehgal (phone)	Discussion about the AIDS programme, discussion about IEC materiall
19.11.93	Catholic Diocese, New Delhi	Archbishop Alan Delastic, New Delhi	Discussion about the AIDS- project of Holy Family Hospital and on the role of the Church in AIDS prevention and care
	National AIDS Control Orgnisation (NACO)	Ms Geeta Sethi - Training	Information about the National AIDS programme
20.11.93	Caritas India, New Delhi	Fr. Yvon Joseph, Dy. Director	Discussion about present and future AIDS activities

CSI COUNCIL FOR HEALING MINISTRY
CONSULTATION -'RESPONDING TO THE CHALLENGE
OF HIV/AIDS IN SOUTH INDIA'
VENUE: YWCA, INTERNATIONAL GUEST HOUSE
27.10.93 - 6 p.m.

PROGRAMME

INVOCATION SONG		
WELCOME	..	DR. RAJKUMARI SUNDER MEDICAL SUPERINTENDENT, CSI RAINY HOSPITAL, MADRAS
INTRODUCTION OPENING REMARKS	..	PROF. A.J. SELVAPANDIAN CONSULTANT, CSI COUNCIL FOR HEALING MINISTRY MADRAS
"AIDS- SHARING THE CHALLENGE"	..	DR. EVA GRABOSCH M.D., M.SC., CHDC, HEIDELBERG MEDICAL MISSION INSTITUTE AIDS AND INTERNATIONAL HEALTH DEPT. SALVATORSTR.22 D-97074 WURZBURG FED.REP OF GERMANY
FELICITATION	..	PROF. GEORGE KOSHY GENERAL SECRETARY, CSI SYNOD MADRAS
VOTE OF THANKS	..	DR. LUKE M. MUTHU MEDICAL SUPERINTENDENT, CSI KALYANI GENERAL HOSPITAL, MADRAS.
DINNER		

PROGRAMME SCHEDULE

VISIT OF DR. EVA GRABOSCH TO HYD.

5.11.1993	Arrival at 7.30 p.m. at Begumpet Airport
6.11.1993	
7.30 a.m.	Breakfast
9.00 - 10.00	Inaugural session of the Convention.
2.00 p.m. - 4.00 p.m.	Sharing session at Vijaya Marie Hospital Doctors, Nurses, and para-medical staff.
5.00 p.m. - 6.30 p.m.	Interview by Dr. Prasad for HAPA
8.00 p.m.	Dinner
7.11.1993	
7.30 a.m.	Breakfast
8.30 a.m. - 10.00 a.m.	Meeting with CHD, MEDIA & Communication & HAPA
10.30 a.m. - 12.30 p.m.	Sharing session with NGOs & Govt.
1.00 p.m.	Lunch
2.00 p.m.	Attending Disaster Relief. Rehabilitation and Preparedness meeting - Jeevan Jyothi

Annex 3

Addresses of Contacted Persons / Institutions

Dr. J.G. Thanekar
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Annex 4

India - Basic data

Size	3,28 mio sqm
Inhabitants	853 mio
Maharashtra	62 mio inhabitants
Tamil Nadu	50 mio inhabitants
Kerala	26 mio inhabitants
Languages	Hindi, English and 15 others
Government	National Front, V.P.Singh, prime minister
States	25 States, 7 Unions
Castes	20 % scheduled castes (paria or harijans) and tribes
Confessions	85 % Hindu (Brahma-Creator, Vishnu-Conserver, Shiva - destroyer), Buddhism and Jainism (0,5 %), 11 % Moslems, 2,6 % Christians
Infant mortality	94 per 1000
Under-five mortality	142 per 1000
Maternal mortality	460 per 100 000
Fertility	4,2
Life expectancy	59 years
School enrolment	99 %
Literacy	average: 48 %, women 34 %, in Kerala 70 %
Minimum salary	Rs 300/m 1.20 DM/day
Exchange rate	20 RS = 1 DM (Oct. 1993)
GNP	340 $US/capita/year
Population below absolute poverty	urban: 29 %, rural: 33 %

Annex 5

Value of money

Prices in October 1993 in Indian Rs (exchange rate: 20 Rs = 1 DM)

Product	Rs
1 kg grain at the market	7
20 kg rice (farmers price)	200
Milk (1l)	12
Cup of coffee/tea	2
1 Coke	7
Mineral water	14
Simple meal in a restaurant	12 - 35
Exclusive meal in a restaurant	65 - 100
Auto-rikscha tour	5-20
Taxi (1h in Bombay)	230
Train (12 h, 1.class)	300
Train (12h, 3.class)	30
Condoms, 3 per pack	2 -7
Bactrim, 10 tabs	19
Salary:	
minimum per day	30
doctor per month	3000 - 50 000
nurse per month	2000 - 6000
rikscha driver per month	2.000
helper per month	1.000
Hotel per bed / night	100 - 800

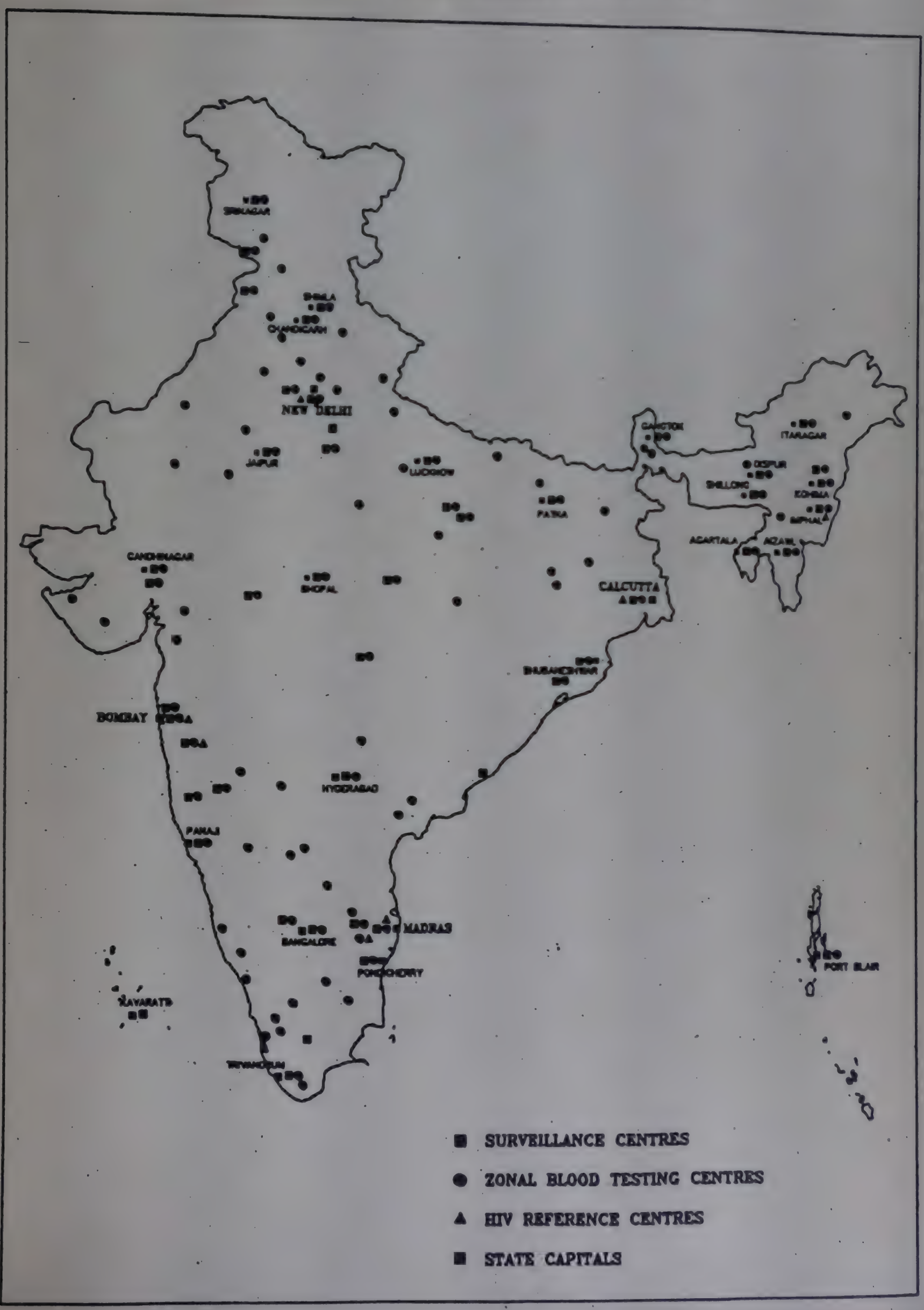
Annex 6

List of some NGOs, that produce IEC material

Organisation	IEC Material produced and/or distributed
MCCSS	Posters, transparencies etc.
CMC Vellore	a booklet with basic information on AIDS, flip-chart with basic information in English and Tamil.
Prepare	handmade posters and flip-chart, slides (a reproduction of the material was recommended)
Heal India	handmade posters, cotton drawings and flip-charts
CHAI	handmade posters, publications in Newsletters, leaflets
IHO	newsletter for prostitutes, IHO Newsletter, booklets with case stories (one abou a PWA, the other about a child prostitute)
AIDS Cell Bombay	posters, leaflets
UNDP	video: "Positive Women", training material for NGO responses on AIDS, AIDS the work place, etc.
National Service Scheme	a manual for students "AIDS education for students' youth - a training manual"
Sr. Shalini, Anti AIDS Movement, ISI	several booklets on human rights issues
All India Institute of Medical Science	video: "Scourge" in English, Hindi, Tamil, Malayalam, Teleju, Kanada and Bengali language
CMAI	leaflets, posters, articles in newsletter etc.
VHAI	posters, leaflets, flyers and the comic "HIV and AIDS - what everybody should know" in six languages
NACO	together with Unicef: a training manual for students. Manuals for doctors and nurse training are in process. For nurses distance training material is being developed.

Annex 7

Location of HIV - Testing Facilities in India in 1993



Annex 8

Organigramme MCCSS

MCCSS
ORGANISATIONAL STRUCTURE

GENERAL BODY

EXECUTIVE COMMITTEE

WORKING COMMITTEE

CORE TEAM

EXECUTIVE SECRETARY

CO-ORDINATOR

P O SECRETA-RIAT	P O HEALTH	P O HUTMENT CORD	P O GOVT LIAISON	P O AIDS	P O COUNSELLING	P O WOMEN's CONCERN	P O TRAINING	P O DOCUMENTATION & RESEARCH

ZONE A | ZONE B | ZONE C | ZONE D | ZONE E | ZONE F | ZONE G | ZONE H

SECRETARIAL STAFF
SHORT STAY HOME STAFF
VOCATIONAL TRAINING STAFF

ZONAL TEAM

FIELD OFFICER

1. HEALTH STAFF
2. HUTMENT CO-ORDINATION STAFF
3. AIDS STAFF
4. WOMEN'S CONCERN STAFF
5. COMMUNITY CENTERS STAFF

Annex 9

Prepare

Golden Jubilee of CHAI

Bharati Women Development Centre

HEALINDIA, TRADA

Private Practioneers

Annex 10

AIDS UPDATE

MONTHLY UPDATE ON HIV INFECTION IN INDIA

(Based on reports received in this organisation)

Period of report upto : 30th September, 1993.

SERO-SURVEILLANCE REPORT

Total number of samples screened :	18,89,670
Number confirmed by Western Blot :	13, 254
Sero-positivity rate (per thousand)	6.98

AIDS CASES IN INDIA

	Male	Female	Total
Indian	336	108	444
Foreigner	11	4	15
Total :	347	112	459

BREAK-UP OF SERO-POSITIVES

CATEGORY	SERO-POSITVE	% OF TOTAL
HETEROSEXUALLY PROMISCUOUS	5,571	42.04
HOMOSEXUALS	41	0.31
BLOOD DONORS	2,165	16.34
DIALYSIS PATIENTS	119	0.90
ANTENATAL MOTHERS	64	0.48
RECIPIENT OF BLOOD, BLOOD/PRODUCT	291	2.20
RELATIVES OF HIV PATIENTS	120	0.91
SUSPECTED ARC/AIDS	595	4.49
I/V DRUG USERS	1,815	13.70
OTHERS	2,473	18.63
TOTAL	13,254	100.00

AIDS IN INDIA

Sept. 1993

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